General Assembly **Substitute Bill No. 5487**

February Session, 2012 *____HB05487INSPD_031512___*

AN ACT CONCERNING THE RECOMMENDATIONS OF THE SMALL BUSINESS HEALTHCARE WORKING GROUP AND CLAIMS INFORMATION REQUIRED TO BE PROVIDED BY INSURERS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 3-123aaa of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

As used in this section and sections 3-123bbb to 3-123hhh, inclusive, as amended by this act:

(1) "Health Care Cost Containment Committee" means the committee established in accordance with the ratified agreement between the state and the State Employees Bargaining Agent Coalition pursuant to subsection (f) of section 5-278.

(2) "Municipal-related employee" means any employee of a municipal-related employer.

(3) "Municipal-related employer" means a property management business, food service business, school transportation business or waste management or recycling authority or business that is a party to a contract with a nonstate public employer.

[(2)**]** (4) "Nonprofit employee" means any employee of a nonprofit

employer.

[(3)**]** (5) "Nonprofit employer" means (A) a nonprofit corporation, organized under 26 USC 501, as amended from time to time, that (i) has a purchase of service contract, as defined in section 4-70b, or (ii) receives fifty per cent or more of its gross annual revenue from grants or funding from the state, the federal government or a municipality or any combination thereof, or (B) an organization that is tax exempt pursuant to 26 USC 501(c)(5), as amended from time to time.

[(4)**]** (6) "Nonstate public employee" means any employee or elected officer of a nonstate public employer.

[(5)**]** (7) "Nonstate public employer" means a municipality or other political subdivision of the state, including a board of education, quasi-public agency or public library. A municipality and a board of education may be considered separate employers.

[(6)**]** (8) "Partnership plan" means a health care benefit plan offered by the Comptroller to nonstate public employers, **[**or**]** nonprofit employers, small employers or municipal-related employers under section 3-123bbb, as amended by this act.

(9) "Small employer employee" means any employee of a small employer.

(10) "Small employer" means a person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months that, on at least fifty per cent of its working days during the preceding twelve months, employed no more than fifty eligible employees, the majority of whom were employed within this state. For the purposes of determining the number of eligible employees under this subdivision, companies that are affiliated companies, as defined in section 33-840, or that are eligible to file a combined tax return for purposes of taxation under chapter 208 shall be considered one employer.

[(7)**]** (11) "State employee plan" means a self-insured group health care benefits plan established under subsection (m) of section 5-259.

Sec. 2. Section 3-123bbb of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(a) (1) Notwithstanding the provisions of title 38a, the Comptroller shall offer to nonstate public employers**,** **[**and**]** nonprofit employers, small employers and municipal-related employers, and their respective retirees, if applicable, coverage under a partnership plan or plans. Such plan or plans may be offered on a fully-insured or risk-pooled basis at the discretion of the Comptroller. A separate prescription drug plan may be offered to small employers and municipal-related employers at the discretion of the Comptroller. Any health insurer, health care center or other entity that contracts with the Comptroller for the purposes of this section and any fully-insured plan offered by the Comptroller under such contract shall be subject to title 38a. Eligible employers shall submit an application to the Comptroller for coverage under any such plan or plans.

(2) Beginning January 1, 2012, the Comptroller shall offer coverage under such plan or plans to nonstate public employers. Beginning January 1, 2013, the Comptroller shall offer coverage under such plan or plans to nonprofit employers. Beginning on or before January 1, 2014, the Comptroller shall offer coverage under such plan or plans to small employers and municipal-related employers.

(b) (1) The Comptroller shall require **[**nonstate public employers and nonprofit**]** all employers that elect to obtain coverage under a partnership plan to participate in such plan for not less than two-year intervals. An employer may apply for renewal prior to the expiration of each interval.

(2) The Comptroller shall develop procedures by which:

(A) Such employers may apply to obtain coverage under a

partnership plan, including procedures for nonstate public employers that are currently fully insured and procedures for nonstate public employers that are currently self-insured;

(B) Employers receiving coverage for their employees pursuant to a partnership plan may (i) apply for renewal, or (ii) withdraw from such coverage, including, but not limited to, the terms and conditions under which such employers may withdraw prior to the expiration of the interval and the procedure by which any premium payments such employers may be entitled to or premium equivalent payments made in excess of incurred claims shall be refunded to such employer. Any such procedures shall provide that nonstate public employees covered by collective bargaining shall withdraw from such coverage in accordance with chapters 113 and 166; and

(C) The Comptroller may collect payments and fees for unreported claims and expenses.

(c) (1) The initial open enrollment for nonstate public employers shall be for coverage beginning July 1, 2012. Thereafter, open enrollment for nonstate public employers shall be for coverage periods beginning July first.

(2) The initial open enrollment for nonprofit employers shall be for coverage beginning January 1, 2013. Thereafter, open enrollment for nonprofit employers shall be for coverage periods beginning January first and July first.

(3) The initial open enrollment for small employers and municipal-related employers shall be for coverage beginning January 1, 2014. Thereafter, open enrollment for small employers and municipal-related employers shall be for coverage periods beginning July first and January first.

(d) Nothing in this section or sections 3-123ccc and 3-123ddd, as amended by this act, shall require the Comptroller to offer coverage to every employer seeking coverage under sections 3-123ccc and 3-

123ddd, as amended by this act, from every partnership plan offered by the Comptroller.

(e) The Comptroller shall create applications for coverage for the purposes of sections 3-123ccc and 3-123ddd, as amended by this act, and for renewal of a partnership plan. Such applications shall require an employer to disclose whether the employer will offer any other health care benefits plan to the employees who are offered a partnership plan.

(f) No employee shall be enrolled in a partnership plan if such employee is covered through such employee's employer by health insurance plans or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

(g) (1) The Comptroller shall take such actions as are necessary to ensure that granting coverage to an employer under sections 3-123ccc and 3-123ddd, as amended by this act, will not affect the status of the state employee plan as a governmental plan under the Employee Retirement Income Security Act of 1974, as amended from time to time. Such actions may include, but are not limited to, cancelling coverage, with notice, to such employer and discontinuing the acceptance of applications for coverage from nonprofit employers, small employers and municipal-related employers. The Comptroller shall establish the form and time frame for the notice of cancellation to be provided to such employer.

(2) The Comptroller shall resume providing coverage for, or accepting applications for coverage from, nonprofit employers, small employers and municipal-related employers if the Comptroller determines that granting coverage to such employers will not affect the state employee plan's status as a governmental plan under the Employee Retirement Income Security Act of 1974, as amended from time to time.

(3) The Comptroller shall make a public announcement of the Comptroller's decision to discontinue or resume coverage or the acceptance of applications for coverage under a partnership plan or plans.

(h) The Comptroller, in consultation with the Health Care Cost Containment Committee, shall:

(1) Develop and implement patient-centered medical homes for the state employee plan and partnership plans offered under this section, in a manner that will reduce the costs of such plans; and

(2) Review claims data of the state employee plan and partnership plans offered under this section, to target high-cost health care providers and medical conditions and monitor costly trends.

(i) (1) Each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing in this state any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall:

(A) Upon request (i) by a nonstate public employer sponsoring such policy, (ii) on or after October 1, 2012, by a nonprofit employer sponsoring such policy, and (iii) on or after October 1, 2013, by a small employer or a municipal-related employer sponsoring such policy, provide to the Comptroller not later than thirty days after receiving such request, free of charge, the following information for the most recent thirty-six-month period or for the entire period of coverage, whichever is shorter, in a format as set forth in subparagraph (C) of this subdivision:

(i) Complete and accurate medical, dental and pharmaceutical utilization data, as applicable;

(ii) Claims paid by year, aggregated by practice type and by service category, each reported separately for in-network and out-of-network

providers, and the total number of claims paid;

(iii) Premiums paid by such employer by month; and

(iv) The number of insureds by coverage tier, including, but not limited to, single, two-person and family including dependents, by month;

(B) Include in such requested information specified in subparagraph (A) of this subdivision only health information that has had identifiers removed, as set forth in 45 CFR 164.514, is not individually identifiable, as defined in 45 CFR 160.103, and is permitted to be disclosed under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or regulations adopted thereunder; and

(C) Provide such requested information in a secure and standardized format prescribed by the Comptroller.

(2) Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall not be required to provide such information to the Comptroller more than once in any twelve-month period.

(3) Any information provided to the Comptroller in accordance with subdivision (1) of this subsection shall not be subject to disclosure under section 1-210.

Sec. 3. Section 3-123ccc of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(a) Nonstate public employers**,** **[**and**]** nonprofit employers, small employers and municipal-related employers may apply for coverage under a partnership plan in accordance with this section.

(1) Notwithstanding any provision of the general statutes, initial

and continuing participation in a partnership plan by a nonstate public employer shall be a permissive subject of collective bargaining and shall be subject to binding interest arbitration only if the collective bargaining agent and the employer mutually agree to bargain over such participation.

(2) If **[**a nonstate public employer or a nonprofit**]** an employer submits an application for coverage for all of its respective employees, the Comptroller shall accept such application upon the terms and conditions applicable to the partnership plan, for the next open enrollment. The Comptroller shall provide written notification to such employer of such acceptance and the date on which such coverage shall begin, pending acceptance by such employer of the terms and conditions of such plan.

(3) (A) Except as specified in subparagraph (D) of this subdivision, if **[**a nonstate public employer or a nonprofit**]** an employer submits an application for coverage for less than all of its respective employees, or indicates in the application the employer will offer other health plans to employees who are offered a partnership plan, the Comptroller shall forward such application to a health care actuary not later than five business days after receiving such application. Not later than sixty days after receiving such application, such actuary shall notify the Comptroller whether, as a result of the employees included in such application or other factors, the application will shift a significant part of such employer's employees' medical risks to the partnership plan. Such actuary shall provide, in writing, to the Comptroller the specific reasons for such actuary's finding, including a summary of all information relied upon in making such a finding.

(B) If the Comptroller determines that, based on such finding, the application will shift a significant part of such employer's employees' medical risks to the partnership plan, the Comptroller shall not provide coverage to such employer and shall provide written notification and the specific reasons for such denial to such employer and the Health Care Cost Containment Committee.

(C) If the Comptroller determines that, based on such finding, the application will not shift a significant part of such employer's employees' medical risks to the partnership plan, the Comptroller shall accept such application for the next open enrollment. The Comptroller shall provide written notification to such employer of such acceptance and the date on which such coverage shall begin, pending acceptance by such employer of the terms and conditions of such plan.

(D) If an employer included less than all of its employees in its application for coverage because of (i) the decision by individual employees to decline coverage from their employer for themselves or their dependents, or (ii) the employer's decision not to offer coverage to temporary, part-time or durational employees, the Comptroller shall not be required to forward such employer's application to a health care actuary.

(b) The Comptroller shall consult with a health care actuary who shall develop:

(1) Actuarial standards to assess the shift in medical risks of an employer's employees to a partnership plan. The Comptroller shall present such standards to the Health Care Cost Containment Committee for its review, evaluation and approval prior to the use of such standards; and

(2) Actuarial standards to determine the administrative fees and fluctuating reserves fees set forth in section 3-123eee, as amended by this act, and the amount of premiums or premium equivalent payments to cover anticipated claims and claim reserves. The Comptroller shall present such standards to the Health Care Cost Containment Committee for its review, evaluation and approval prior to the use of such standards.

(c) The Comptroller may adopt regulations, in accordance with chapter 54, to establish the procedures and criteria for any reviews or evaluations performed by the Health Care Cost Containment

Committee pursuant to subsection (b) of this section or subsection (c) of section 3-123ddd.

Sec. 4. Subdivision (2) of subsection (b) of section 3-123ddd of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(2) Except as specified in subdivision (5) of this subsection, if **[**a nonstate public employer or a nonprofit**]** an employer seeks coverage for less than all of its respective retirees, regardless of whether the employer is seeking coverage for all of such employer's active employees, the Comptroller shall forward such application to a health care actuary not later than five business days after receiving such application. Not later than sixty days after receiving such application, such actuary shall notify the Comptroller whether, as a result of the retirees included in such application or other factors, the application will shift a significant part of such employer's retirees' medical risks to the partnership plan. Such actuary shall provide, in writing, to the Comptroller the specific reasons for such actuary's finding, including a summary of all information relied upon in making such a finding.

Sec. 5. Subdivision (5) of subsection (b) of section 3-123ddd of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(5) If an employer included less than all of its retirees in its application for coverage because of (A) the decision by individual retirees to decline health benefits or health insurance coverage from their employer for themselves or their dependents, or (B) the retiree's enrollment in Medicare, the Comptroller shall not be required to forward such employer's application to a health care actuary.

Sec. 6. Subdivision (1) of subsection (d) of section 3-123eee of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(1) The Comptroller may terminate participation in the partnership

plan by a nonprofit employer, small employer or municipal-related employer on the basis of nonpayment of premium or premium equivalent, provided at least ten days' advance notice is given to such employer, which may continue the coverage and avoid the effect of the termination by remitting payment in full at any time prior to the effective date of termination.

Sec. 7. Section 3-123fff of the 2012 supplement to the general statutes is amended by adding subsection (c) as follows (*Effective July 1, 2012*):

(NEW) (c) There is established a Private Sector Health Care Advisory Committee. The committee shall make advisory recommendations to the Health Care Cost Containment Committee concerning health care coverage for small employer employees and municipal-related employees. The advisory committee shall consist of small employers and municipal-related employers and their respective employees participating in a partnership plan and shall include the following members appointed by the Comptroller: (1) Two small employer representatives; (2) two small employer employee representatives; (3) two municipal-related employer representatives; and (4) two municipal-related employee representatives.

Sec. 8. Section 38a-567 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

Health insurance plans and insurance arrangements covering small employers and insurers and producers marketing such plans and arrangements shall be subject to the following provisions:

(1) (A) (i) Any such insurer or producer marketing such plans or arrangements shall offer premium quotes to small employers upon request for coverage for employees who work a normal work week of thirty or more hours. Upon request by a small employer, such insurer or producer shall offer premium quotes for coverage for employees that include those who work a normal work week of at least twenty

hours.

(ii) No small employer that has requested premium quotes for coverage for employees that include those who work a normal work week of less than thirty hours shall be required to accept such quotes or coverage in lieu of premium quotes or coverage for only those employees who work a normal work week of thirty or more hours.

(iii) Nothing in this subparagraph shall require a small employer that offers coverage to its employees who work a normal work week of thirty hours or more to offer coverage to its employees who work a normal work week of less than thirty hours.

(B) Any such plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the small employer, policyholder or contractholder, as the case may be, except: (i) For nonpayment of the required premiums by the small employer, policyholder or contractholder; (ii) for fraud or misrepresentation of the small employer, policyholder or contractholder or, with respect to coverage of individual insured, the insureds or their representatives; (iii) for noncompliance with plan or arrangement provisions; (iv) when the number of insureds covered under the plan or arrangement is less than the number of insureds or percentage of insureds required by participation requirements under the plan or arrangement; or (v) when the small employer, policyholder or contractholder is no longer actively engaged in the business in which it was engaged on the effective date of the plan or arrangement.

(C) Renewability of coverage may be effected by either continuing in effect a plan or arrangement covering a small employer or by substituting upon renewal for the prior plan or arrangement the plan or arrangement then offered by the carrier that most closely corresponds to the prior plan or arrangement and is available to other small employers. Such substitution shall only be made under conditions approved by the commissioner. A carrier may substitute a plan or arrangement as stated above only if the carrier effects the same

substitution upon renewal for all small employers previously covered under the particular plan or arrangement, unless otherwise approved by the commissioner. The substitute plan or arrangement shall be subject to the rating restrictions specified in this section on the same basis as if no substitution had occurred, except for an adjustment based on coverage differences.

(D) Notwithstanding the provisions of this subdivision, any such plan or arrangement, or any coverage provided under such plan or arrangement may be rescinded for fraud, intentional material misrepresentation or concealment by an applicant, employee, dependent or small employer.

[(E) Any individual who was not a late enrollee at the time of his or her enrollment and whose coverage is subsequently rescinded shall be allowed to reenroll as of a current date in such plan or arrangement subject to any preexisting condition or other provisions applicable to new enrollees without previous coverage. On and after the effective date of such individual's reenrollment, the small employer carrier may modify the premium rates charged to the small employer for the balance of the current rating period and for future rating periods, to the level determined by the carrier as applicable under the carrier's established rating practices had full, accurate and timely underwriting information been supplied when such individual initially enrolled in the plan. The increase in premium rates allowed by this provision for the balance of the current rating period shall not exceed twenty-five per cent of the small employer's current premium rates. Any such increase for the balance of said current rating period shall not be subject to the rate limitation specified in subdivision (6) of this section. The rate limitation specified in this section shall otherwise be fully applicable for the current and future rating periods. The modification of premium rates allowed by this subdivision shall cease to be permitted for all plans and arrangements on the first rating period commencing on or after July 1, 1995.**]**

(2) Except in the case of a late enrollee who has failed to provide

evidence of insurability satisfactory to the insurer, the plan or arrangement may not exclude any eligible employee or dependent who would otherwise be covered under such plan or arrangement on the basis of an actual or expected health condition of such person. No plan or arrangement may exclude an eligible employee or eligible dependent who, on the day prior to the initial effective date of the plan or arrangement, was covered under the small employer's prior health insurance plan or arrangement pursuant to workers' compensation, continuation of benefits pursuant to section 38a-554 or other applicable laws. The employee or dependent must request coverage under the new plan or arrangement on a timely basis and such coverage shall terminate in accordance with the provisions of the applicable law.

[(3) (A) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, the premium rates charged or offered for a rating period for all plans and arrangements may not exceed one hundred thirty-five per cent of the base premium rate for all plans or arrangements.

(B) For rating periods commencing on or after July 1, 1994, and prior to July 1, 1995, the premium rates charged or offered for a rating period for all plans or arrangements may not exceed one hundred twenty per cent of the base premium rate for such rating period. The provisions of this subdivision shall not apply to any small employer who employs more than twenty-five eligible employees.

(4) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1995, the percentage increase in the premium rate charged to a small employer, who employs not more than twenty-five eligible employees, for a new rating period may not exceed the sum of:

(A) The percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(B) An adjustment of the small employer's premium rates for the

prior rating period, and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer, such adjustment (i) not to exceed ten per cent annually for the rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, and (ii) not to exceed five per cent annually for the rating periods commencing on or after July 1, 1994, and prior to July 1, 1995; and

(C) Any adjustments due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's applicable rate manual.**]**

[(5)**]** (3) (A) With respect to plans or arrangements issued on or after July 1, 1995, the premium rates charged or offered to small employers shall be established on the basis of a community rate, adjusted to reflect one or more of the following classifications:

(i) Age, provided age brackets of less than five years shall not be utilized;

(ii) Gender;

(iii) Geographic area, provided an area smaller than a county shall not be utilized;

(iv) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

(v) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

(vi) Administrative cost savings resulting from the administration of

an association group plan or a plan written pursuant to section 5-259, provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions;

(vii) Savings resulting from a reduction in the profit of a carrier who writes small business plans or arrangements for an association group plan or a plan written pursuant to section 5-259 provided any loss in overall revenue due to a reduction in profit is not shifted to other small employers; and

(viii) Family composition, provided the small employer carrier shall utilize **[**only**]** one or more of the following billing classifications only: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; and (VI) employee plus two or more dependents.

(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the small employer group. No small employer carrier may inquire regarding health status or claims experience of the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. **[**The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.**]**

[(6)**]** (4) For any small employer plan or arrangement on which the premium rates for employee and dependent coverage or both, vary among employees, such variations shall be based solely on age and other demographic factors permitted under subparagraph (A) of

subdivision **[**(5)**]** (3) of this section and such variations may not be based on health status, claim experience **[**,**]** or duration of coverage of specific enrollees. Except as otherwise provided in subdivision (1) of this section, any adjustment in premium rates charged for a small employer plan or arrangement to reflect changes in case characteristics prior to the end of a rating period shall not include any adjustment to reflect the health status, medical history or medical underwriting classification of any new enrollee for whom coverage begins during the rating period.

[(7) For rating periods commencing prior to July 1, 1995, in any case where a small employer carrier utilized industry classification as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary from the arithmetical average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average.**]**

[(8)**]** (5) Differences in base premium rates charged for health benefit plans by a small employer carrier shall be reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

[(9) For rating periods commencing prior to July 1, 1995, in any case where an insurer issues or offers a policy or contract under which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claim costs or actual or expected variation in health conditions of the employees or dependents of such small employer, the insurer shall make reasonable disclosure of such rating practices in solicitation and sales materials utilized with respect to such policy or contract.**]**

[(10)**]** (6) If a small employer carrier denies coverage or a small employer carrier or any producer representing that carrier fails, for any reason, to offer coverage, as requested to a small employer that is

self-employed, the small employer carrier shall promptly offer such small employer the opportunity to purchase a small employer health care plan. **[**If a small employer carrier or any producer representing that carrier fails, for any reason, to offer coverage as requested by a small employer that is self-employed, that small employer carrier shall promptly offer such small employer an opportunity to purchase a small employer health care plan.**]**

[(11)**]** (7) No small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(A) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer, except the provisions of this subparagraph shall not apply to information provided by a small employer carrier or producer to a small employer regarding the carrier's established geographic service area or a restricted network provision of a small employer carrier; or

(B) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

[(12)**]** (8) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small employer. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a special or a small employer health care plan. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by

the producer with the small employer carrier.

[(13)**]** (9) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

[(14)**]** (10) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reasons for the denial.

[(15)**]** (11) No small employer carrier or producer shall disclose (A) to a small employer the fact that any or all of the eligible employees of such small employer have been or will be reinsured with the pool, or (B) to any eligible employee or dependent the fact that he has been or will be reinsured with the pool.

[(16)**]** (12) If a small employer carrier enters into a contract, agreement or other arrangement with another party to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the other party shall be subject to the provisions of this section.

[(17)**]** (13) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers.

[(18)**]** (14) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. Each small employer carrier shall file with the commissioner annually, on or before March fifteenth, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods have

been derived using recognized actuarial principles consistent with the provisions of sections 38a-564 to 38a-573, inclusive, as amended by this act. Such certification shall be in a form and manner and shall contain such information as determined by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business. Any information and documentation described in this subdivision but not subject to the filing requirement shall be made available to the commissioner upon his request. Except in cases of violations of sections 38a-564 to 38a-573, inclusive, as amended by this act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

[(19)**]** (15) The commissioner may suspend all or any part of this section relating to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

[(20) For rating periods commencing prior to July 1, 1995, a small employer carrier shall quote premium rates to any small employer within thirty days after receipt by the carrier of such employer's completed application.**]**

[(21)**]** (16) Any violation of subdivisions **[**(10)**]** (6) to **[**(16)**]** (12), inclusive, of this section and of any regulations established under subdivision **[**(17)**]** (13) of this section shall be an unfair and prohibited practice under sections 38a-815 to 38a-830, inclusive.

[(22) (A)**]** (17) With respect to plans or arrangements issued pursuant to subsection (i) of section 5-259, at the option of the Comptroller, the premium rates charged or offered to small employers

purchasing health insurance shall not be subject to this section, provided **[**(i)**]** (A) the plan or plans offered or issued cover such small employers as a single entity and cover not less than three thousand employees on the date issued, **[**(ii)**]** (B) each small employer is charged or offered the same premium rate with respect to each employee and dependent, and **[**(iii)**]** (C) the plan or plans are written on a guaranteed issue basis.

[(B)**]** (18) (A) With respect to plans or arrangements **[**issued**]** offered by an association, **[**group plan, at the option of the administrator of the association group plan,**]** an insurer issuing health insurance plans and insurance arrangements covering employers in this state shall offer premium quotes upon request by an association that meets the provisions of this subdivision for an association group plan under which the premium rates charged or offered to small employers purchasing health insurance under this subdivision shall not be subject to this section, provided (i) the plan or plans offered or issued cover such small employers as a single entity and cover not less than three thousand employees on the date issued, (ii) each small employer is charged or offered the same premium rate with respect to each employee and dependent, and (iii) the plan or plans are written on a guaranteed issue basis. In addition, such association **[**group (I)**]** shall be a bona fide group as set forth in the Employee Retirement and Security Act of 1974 **[**, (II)**]** and shall not be formed for the purposes of fictitious grouping, as defined in section 38a-827. **[**, and (III) shall not issue any plan that shall cause undue disruption in the insurance marketplace, as determined by the commissioner.**]**

(B) No association that requests premium quotes for an association group plan shall be required to accept such premium quotes or association group plan. An insurer shall not issue any plan that shall cause undue disruption in the insurance marketplace, as determined by the commissioner.

Sec. 9. Subdivision (28) of section 38a-564 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu

thereof (*Effective July 1, 2012*):

(28) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of **[**subdivisions**]** subdivision (4) **[**, (6), (7) and (9)**]** of section 38a-567, as amended by this act, and the regulations promulgated by the commissioner pursuant to section 38a-567, as amended by this act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

Sec. 10. Subsection (b) of section 38a-569 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(b) Any member may reinsure with the pool coverage of an eligible employee of a small employer, or any dependent of such an employee, except that no member may reinsure with the pool coverage of an eligible employee of a small employer, or any dependent of such an employee, whose premium rates are not subject to section 38a-567, as amended by this act, pursuant to subdivision **[**(22)**]** (17) or (18) of section 38a-567, as amended by this act. Any reinsurance placed with the pool from the date of the establishment of the pool regarding the coverage of an eligible employee of a small employer, or any dependent of such an employee shall be provided as follows:

(1) (A) With respect to a special health care plan or a small employer health care plan, the pool shall reinsure the level of coverage provided; (B) with respect to other plans, the pool shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in a small employer health care plan or the actuarial equivalent thereof as defined and authorized by the board; and (C) in either case, no reinsurance may be provided in any calendar year for a reinsured employee or dependent until five thousand dollars in benefit

payments have been made for services provided during that calendar year for that reinsured employee or dependent, which payments would have been reimbursed through said reinsurance in the absence of the annual five-thousand-dollar deductible. The amount of the deductible shall be periodically reviewed by the board and may be adjusted for appropriate factors as determined by the board;

(2) With respect to eligible employees, and their dependents, coverage may be reinsured: (A) Within such period of time after the commencement of their coverage under the plan as may be authorized by the board, or (B) commencing January 1, 1992, on the first plan anniversary after the employer's coverage has been in effect with the small employer carrier for a period of three years, and every third plan anniversary thereafter, provided, commencing May 1, 1994, reinsurance pursuant to this subparagraph shall only be permitted with respect to eligible employees and their dependents of a small employer which has no more than two eligible employees as of the applicable anniversary;

(3) Reinsurance coverage may be terminated for each reinsured employee or dependent on any plan anniversary;

(4) Reinsurance of newborn dependents shall be allowed only if the mother of any such dependent is reinsured as of the date of birth of such child, and all newborn dependents of reinsured persons shall be automatically reinsured as of their date of birth; and

(5) Notwithstanding the provisions of subparagraph (A) of subdivision (2) of this subsection: (A) Coverage for eligible employees and their dependents provided under a group policy covering two or more small employers shall not be eligible for reinsurance when such coverage is discontinued and replaced by a group policy of another carrier covering two or more small employers, unless coverage for such eligible employees or dependents was reinsured by the prior carrier; and (B) at the time coverage is assumed for such group by a succeeding carrier, such carrier shall notify the pool of its intention to

provide coverage for such group and shall identify the employees and dependents whose coverage will continue to be reinsured. The time limitations for providing such notice shall be established by the pool.

Sec. 11. Section 38a-513 of the 2012 supplement to the general statutes is amended by adding subsection (e) as follows (*Effective July 1, 2012*):

(NEW) (e) An insurance company or health care center that delivers or issues for delivery a group health insurance policy or plan in this state shall offer premium quotes to a large employer upon request for coverage for its employees. No such employer that requests premium quotes for such coverage shall be required to accept such premium quotes or coverage.

Sec. 12. Section 38a-591 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(a) For purposes of this section, "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

(b) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center licensed to do business in the state shall comply with Sections 1251, 1252 and 1304 of the Affordable Care Act and the following Sections of the Public Health Service Act, as amended by the Affordable Care Act: (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A, inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

(c) This section shall apply, on and after the effective dates specified in the Affordable Care Act, to insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations and health care centers licensed to do business in the state.

(d) No provision of the general statutes concerning a requirement of

the Affordable Care Act shall be construed to supersede a provision of the general statutes that provides greater protection to an insured, except to the extent the latter prevents the application of a requirement of the Affordable Care Act.

(e) Not later than sixty days after the Secretary of the United States Department of Health and Human Services (1) issues final regulations for the methodology for calculating the actuarial value of individual and small employer health insurance policies and health care plans, or (2) makes publicly available any applicable calculator or applicable data necessary to perform such calculations, each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center that delivers, issues for delivery, renews, amends or continues a health plan of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall disclose to each policyholder or subscriber, in writing, the actuarial value of the health insurance policy or health care plan under which such policyholder or subscriber is insured or enrolled.

[(e)**]** (f) The Insurance Commissioner may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

Sec. 13. Section 38a-513f of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(a) As used in this section:

(1) "Claims paid" means the amounts paid for the covered employees of an employer by an insurer, health care center, hospital service corporation, medical service corporation or other entity as specified in subsection (b) of this section for medical services and supplies and for prescriptions filled, but does not include expenses for stop-loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features, administrative costs or

profit.

(2) "Employer" means any **[**town, city, borough, school district, taxing district or fire district**]** employer employing more than fifty employees.

(3) "Utilization data" means (A) the aggregate number of procedures or services performed for the covered employees of the employer, by practice type and by service category, or (B) the aggregate number of prescriptions filled for the covered employees of the employer, by prescription drug name.

(b) Each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing in this state any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall:

(1) Not later than October first, annually, provide to an employer sponsoring such policy, free of charge, the following information for the most recent thirty-six-month period or for the entire period of coverage, whichever is shorter, and ending not **[**more than sixty days prior to the date of the request**]** earlier than the preceding August first, in a format as set forth in subdivision (3) of this subsection:

(A) Complete and accurate medical, dental and pharmaceutical utilization data, as applicable;

(B) Claims paid by year, aggregated by practice type and by service category, each reported separately for in-network and out-of-network providers, and the total number of claims paid;

(C) Premiums paid by such employer by month; and

(D) The number of insureds by coverage tier, including, but not limited to, single, two-person and family including dependents, by month;

(2) Include in such **[**requested**]** information specified in subdivision (1) of this subsection only health information that has had identifiers removed, as set forth in 45 CFR 164.514, is not individually identifiable, as defined in 45 CFR 160.103, and is permitted to be disclosed under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or regulations adopted thereunder; and

(3) Provide such **[**requested**]** information **[**(A) in a written report, (B) through an electronic file transmitted by secure electronic mail or a file transfer protocol site, or (C) through a secure web site or web site portal that is accessible by such employer**]** in a secure and standardized format prescribed by the Comptroller.

(c) Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall not be required to provide such information to the employer more than once in any twelve-month period.

(d) (1) Except as provided in subdivision (2) of this subsection, information provided to an employer pursuant to subsection (b) of this section shall be used by such employer only for the purposes of obtaining competitive quotes for group health insurance or to promote wellness initiatives for the employees of such employer.

(2) Any employer may provide to the Comptroller upon request the information disclosed to such employer pursuant to subsection (b) of this section. The Comptroller shall maintain as confidential any such information.

(e) Any information provided to an employer in accordance with subsection (b) of this section or to the Comptroller in accordance with subdivision (2) of subsection (d) of this section shall not be subject to disclosure under section 1-210. An employee organization, as defined in section 7-467, that is the exclusive bargaining representative of the employees of such employer shall be entitled to receive claim

information from such employer in order to fulfill its duties to bargain collectively pursuant to section 7-469.

(f) If a subpoena or other similar demand related to information provided pursuant to subsection (b) of this section is issued in connection with a judicial proceeding to an employer that receives such information, such employer shall immediately notify the insurer, health care center, hospital service corporation, medical service corporation or other entity that provided such information to such employer of such subpoena or demand. Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall have standing to file an application or motion with the court of competent jurisdiction to quash or modify such subpoena. Upon the filing of such application or motion by such insurer, health care center, hospital service corporation, medical service corporation or other entity, the subpoena or similar demand shall be stayed without penalty to the parties, pending a hearing on such application or motion and until the court enters an order sustaining, quashing or modifying such subpoena or demand.

Sec. 14. Section 38a-513g of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(a) For the purposes of this section, "employer" **[**has the same meaning as provided in section 38a-513f**]** means any town, city, borough, school district, taxing district or fire district employing more than fifty employees.

(b) Not later than October first, annually, each employer that sponsors a fully insured group health insurance policy for its active employees, early retirees and retirees that provides coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall submit electronically to the Comptroller, in a form prescribed by the Comptroller, the following information: For the two policy years immediately preceding, the percentage increase or

decrease in the policy or plan costs, calculated as the total premium costs, inclusive of any premiums or contributions paid by active employees, early retirees and retirees, divided by the total number of active employees, early retirees and retirees covered by such policy.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2012*	3-123aaa
Sec. 2	*July 1, 2012*	3-123bbb
Sec. 3	*July 1, 2012*	3-123ccc
Sec. 4	*July 1, 2012*	3-123ddd(b)(2)
Sec. 5	*July 1, 2012*	3-123ddd(b)(5)
Sec. 6	*July 1, 2012*	3-123eee(d)(1)
Sec. 7	*July 1, 2012*	3-123fff
Sec. 8	*July 1, 2012*	38a-567
Sec. 9	*July 1, 2012*	38a-564(28)
Sec. 10	*July 1, 2012*	38a-569(b)
Sec. 11	*July 1, 2012*	38a-513
Sec. 12	*July 1, 2012*	38a-591
Sec. 13	*July 1, 2012*	38a-513f
Sec. 14	*July 1, 2012*	38a-513g

INS *Joint Favorable Subst. C/R* PD